4.4.3 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))**

Delaware uses a joint application form for Medicaid and Title XXI. Our automated eligibility system, DCIS II, incorporates a set of eligibility rules that explore the most beneficial and comprehensive benefits for applicants and recipients. Applicant and recipient data is evaluated through a "cascade" of Medicaid programs. If the applicant or recipient is found ineligible for Medicaid, the system automatically explores eligibility for Title XXI.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The Delaware Title XXI program is targeted to uninsured children and is not expected to supplant any health insurance currently provided to any applicant. Delaware's approach to crowd out is:

The joint application asks whether the applicant has had health insurance within the last six months. Children are not eligible for the Delaware Title XXI program unless they have been without health coverage for at least the six preceding months. Exceptions to this would be made if coverage is lost due to:

- ***death of parent,***
- ***disability of parent,***
- ***termination of employment,***
- ***change to a new employer who does not cover dependents,***
- ***change of address so that no employer-sponsored coverage is available,***
- ***expiration of the coverage periods established by COBRA***
- ***employer terminating health coverage as a benefit for all employees.***

The recommendation for enforcement of this provision is: Simple declaration at the time of application and during each redetermination.

The joint application asks whether the applicant currently has health insurance at initial application and at redetermination. The Third Party Liability Unit verifies this information.

Delaware will monitor the data collected from the application on private coverage, looking for trends on substitution of coverage over time.

4.4.4.2 ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: Describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

American Indian and Alaska Native children are eligible for the Delaware Healthy Children Program on the same basis as any other children in Delaware. All children in Delaware who may be eligible will be targeted through outreach efforts specifically outlined in Section 5.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☒ Information strategies
7.1.4. ☒ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42 CFR 457.495)**

NOTE: These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

MCO's must have an internal written quality assurance plan (QAP) that monitors, assures, and approves the quality of care delivered over a wide range of clinical and health service delivery areas to include, but are not limited to:

- ***Well baby care;***
- ***Well child care;***
- ***Pediatric and adolescent development; and,***
- ***Immunizations.***

Plans are also required to report semi-annually results of their internal monitoring. This will include the reporting of the above-referenced HEDIS indicators.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR §457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

Delaware will expect its contracting Medicaid MCOs to use existing provider panels to provide services to the DHCP. The State requires MCOs to maintain that ratio for the DHCP. The MMIS provides weekly reports on MCO capacity. These reports are monitored by DSHP staff. The MCOs are notified of access issues and the need to add providers. Delaware Medicaid's contracting MCOs have contracts with all of the State's hospitals for outpatient and emergency care. A majority of Delaware's physician providers also contract with the Medicaid MCOs. The State's contracting MCOs report percentage of primary providers with open panels on a quarterly basis to DSHP.

The state requires the "prudent layperson" language for emergency services as defined by the BBA of 1997. This regulation also restricts

the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

The State will perform consumer satisfaction surveys and will require the MCOs to perform consumer satisfaction surveys. Issues related to access are an integral part of these surveys. The State uses a modified CAHPs survey for the DSHP and will use the same methodology for the DHCP. The State also uses grievance and complaint records for DSHP to identify MCO panels that may be reaching capacity. These methods have worked well for DSHP and we would expect the same results for the DHCP.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

Benefit procedures exist for members with chronic, complex, or serious conditions. All of the managed care organizations must comply with regulations regarding access to and adequacy of specialists.

During enrollment, the Health Benefits Manager screens enrollees with chronic, complex, or serious medical conditions and refers this information to the MCOs. The MCOs utilize case managers to assure appropriate access to care for children with serious health care needs.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

The state complies with SCHIP requirement of decisions related to the prior authorization of health services within 14 days after receipt of request.

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Since cost sharing is per family per month (PFPM), rather than per member per month, each family will pay the same amount no matter the number of children in the household. The premium rates are significantly less than those allowed by the Balance Budget Act of 1997 for premiums (see chart below). There is a minimal copayment of $10 per inappropriate use of the emergency room that will be waived if a prudent layperson would deem the visit an emergency or if it results in an inpatient admission. Delaware believes these levels of cost sharing are affordable but, at the same time, provide an incentive for clients to responsibly use health care services and avoid unnecessary emergency room visits.

An analysis of the State's fee schedule suggests that cumulative cost-sharing will rarely exceed 1% of the family's adjusted gross income. However, should families submit evidence that they have reached the aggregate limit on cost-sharing, the State will work with the MCOs on an individual basis to exempt the family from future cost-sharing.

Premiums as a percentage of Income

*% of FPL**	*Family Size*	*101%*	*133%*	*134%*	*166%*	*167%*	*200%*
$120 Annual Premium	1	1.47%	1.12%				
	2	1.09%	0.83%				
	3	0.87%	0.66%				
$180 Annual Premium	1			1.66%	1.35%		
	2			1.23%	1%		
	3			0.98%	0.79%		
$300 Annual Premium	1					2.23%	1.86%
	2					1.65%	1.38%
	3					1.32%	1.1%

* Based on the 1998 Poverty Limit of $8050 for 1 person, $10,850 for 2, and $13,650 for 3.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

Delaware's application form asks for race group including American Indian/Alaskan Native and we accept self-declaration. This information is included in the automated record, which enables us to exclude these families from premium requirements. We will add a statement to the approval notices indicating that American Indian/Alaskan Native families are exempt from premium requirements. The approval notices include a toll free contact number. To exclude American Indian/Alaska Native enrollees from any copayments on non-emergent use of emergency room services, the premium and approval notices will include a statement advising families the AI/AN families are exempt. The notices will advise AI/AN families to call the Health Benefits Manager (HBM) at a toll-free number to identify themselves and request an exemption. MMIS has an exemption code that must be manually entered by the HBM.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not

pay a charge**. (42CFR 457.570 and 457.505(c))**

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. A notice of cancellation will be sent to the family advising the family to report any change in circumstances, such as a decrease in income that may result in eligibility for Medicaid. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate**. (42CFR 457.570(b))**

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements**. (Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)***

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**